Improving Access *Improving Coordination* *Empowering People*

MAKING MEDICAID BETTER - 2012 - A YEAR IN TRANSITION

Louisiana Public Health Association Conference
April 11. 2013

2012 - A Year in Transition

- Bayou Health transformed Louisiana's 30-year-old legacy unmanaged fee-for-service to managed health care delivery system for 900,000 Medicaid and LaCHIP recipients. This new system changed:
  - How providers do business with Medicaid;
  - How recipients receive services; and
  - The organizational and functional responsibilities of Medicaid.

The goal of Bayou Health was to:
Make Medicaid Better

Success Stories - Outreach to Providers

- Provider Meetings with individuals, organizations and clinics
- Direct Communication with Providers through notices, RA messages, newsletters and Provider update articles
- Daily Provider Calls starting January 2012 with Bayou Health Director
- Rapid Response "War Room" first two week's of each Geographic Service Area implementation
- Daily Provider Calls for the first 12 months of operation
- Informational Bulletins for fast access as response to most pressing provider issues, many developed through information shared in daily provider calls. Notification of update or addition to IBs sent by e-mail to e-news mailing list
- Making Medicaid Better Web site resource - FAQs, contracts, reporting, contacts, latest provider news
- Provider engagement in committees - Administrative Simplification Committee, Bayou Health Quality Committee, Health Plan Advisory Committees

Outreach to Members

- Enrollment packet sent to each Bayou Health-eligible household with:
  - Plan comparison chart, brochure from each Plan
  - Enrollment form, postage paid envelope
- 30 days to choose Plan, 90 days to transfer to another Plan after choice
- Campaign to encourage active choice – media (radio, TV, print) , reminder calls, postcards and over 500 in-person meetings (Choose Health and immersion sites places - where Medicaid recipients naturally gather)
- Multiple access points for enrollment – phone, fax, in-person meeting, online, mail
- Advocacy meetings to engage community organizations in education and outreach

Bayou Health: Making Medicaid Better

- Bayou Health is "first and foremost" committed to improving the health of our enrollees by giving them the ability to choose their healthcare options.
- Core of Bayou Health's mission:
  - Better quality of care and improved health outcomes through a focus on
    - prevention,
    - better coordination of care,
    - interventions to actively manage chronic illnesses; and
    - a comprehensive patient-centered medical home.
  - Increased access to care, including enforceable time and distance requirements, Prepaid may negotiate rates with specialists and the ability of the Prepaid Plans to contract with providers currently unwilling to enroll in Louisiana Medicaid.

Transition: Before and During Implementation

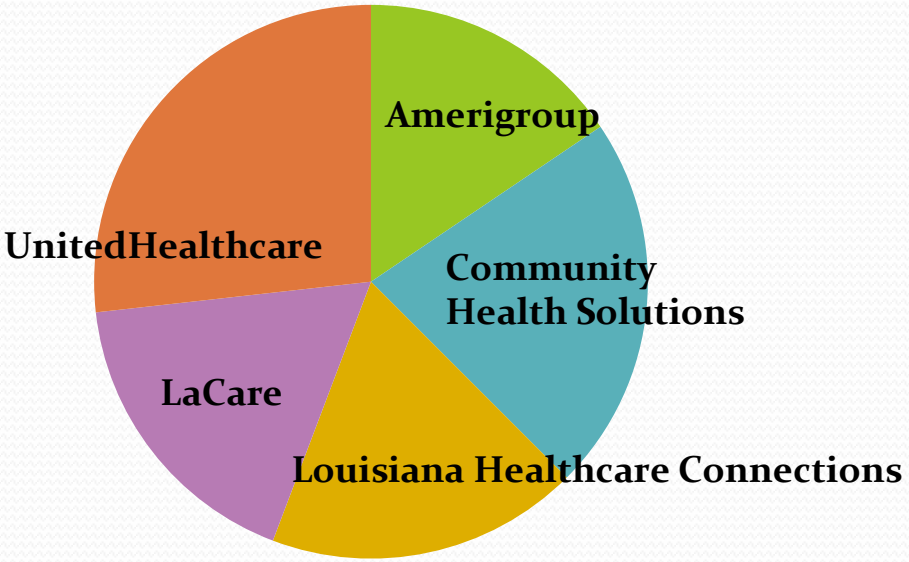
- **Initial Enrollment** – effective February – June, 2012
  - Approximately 300,000 enrollees phased in at a time
  - Three enrollment periods based on geographic service areas
- **New Services** – effective November 1, 2012
  - Pharmacy - for Prepaid Health Plans only *(Shared Savings Health Plan enrollees receive services direct from Louisiana Medicaid legacy providers)*
- **New Populations** – effective January 1, 2013
  - LaCHIP Affordable Plan
- **New Processes** – effective October 1, 2012
  - Pregnant Women automatically enrolled in Health Plan during first month of enrollment.

Populations Not Covered in Bayou Health

- Individuals with both Medicare and Medicaid (Medicaid is their secondary payer)
- *Chisholm* class members
- Recipients enrolled in:
  - ***Take Charge*** family planning waiver,
  - Greater New Orleans Community Health Connection (GNOCHC)
  - **LaHIPP** premium reimbursement
- Persons with a limited eligibility period including:
  - Spend-down Medically Needy Program
  - Refugee Medical Assistance Program
  - Emergency services only
- Persons in a nursing or DD facility
- HCBS waiver recipients, regardless of the age or waiver
- Persons receiving hospice services

Where are the Members Enrolled?

Market Share by Plan



Amerigroup	139,961
Community Health Solutions	197,578
Louisiana Healthcare Connections	165,411
LaCare	157,226
UnitedHealthcare	240,937
Total	901,113

As of March 2013

Bayou Health vs. Fee for Service Program Requirements

Bayou Health Plans	Fee-for-Service Providers
Network Adequacy - Distance and Time, Appointment Times	None
Case management services for high-risk recipients	None
Coordination and Continuity of Care	None
Accountability for Health Outcomes	None
Prompt Pay/Pre-processing Timeline requirements	None
Chronic care management services	None
Guaranteed access to services	None
Dedicated Member Services Staff	None
Required Reporting	None
Quality Management Performance Improvement Projects	None
Medical Loss Ratio Requirement	None

Who are our Bayou Health partners?

Business Partners to Improve Care

What are the differences in the two Bayou Health Models?

	Prepaid Health Plans	Shared Savings Health Plans
Network Providers	PCPs, Specialist, Hospitals, and others (may contract with providers not enrolled in Medicaid)	PCPs only (specialist and hospital care available through the Medicaid contracted providers)
Network Access	Must guarantee access to ALL provider types in network	Must guarantee access to PCPs only
Referral policies	Yes	Yes
Disease Management and Wellness Programs	Yes	Yes
Extra Benefits Offered	Yes	No
Per member Per Month Payment	$246.50 – Full risk	$10.54 – $15.74 (partial risk)
Claims Processing	Claims for core benefits and services will be processed and paid by the Plan within: ○ 15 business days – 90% of all provider types ○ 30 calendar days – all provider types	Claims for core benefits and services (except DME, pharmacy, non emergency medical transportation, etc.) for members will be pre-processed (2 business days) and sent to the state's fiscal intermediary for payment

What does Bayou Health bring to the table?

- Identifying and managing high risk pregnancies
- Collectively increasing 500% the physician oversight and coordination of care for Medicaid enrollees.
- Active case management for approximately 25,054 members
- Focusing on members repeatedly seen in the Emergency Room for non-emergent conditions (“frequent flyers”)
- Increasing resources available for Medicaid pharmacy benefits management
- Empowering members to manage their own health
- Providing intensive technical assistance and other supports to more than contract primary care provider locations
- Reducing state dollars that would have been spent for Medicaid benefits

What does Bayou Health bring to the table?

- Value added services and benefits differ with each Plan
- Expanded Benefits
  - Care Coordination
  - Chronic Care Management
  - Case Management for High-Risk/Specials Needs recipients
  - Unlimited PCP visits for adults
  - Dental exams and screening services for adults *
  - Adult eye exams with $10 copay and $40 allowance for glasses*

    **Not applicable to all plans*
- Incentives
  - Reward Cards for healthy behavior
  - Wellness programs
  - Coverage for Over the Counter Medicines

Member Incentives

2012 Value Added Benefits

Amerigroup RealSolutions in healthcare

Value added benefit	# of Members	% of total Members
Weight Watchers	718	.52%
Entertainment Coupon	137	.10%
Disaster Kit	102	.07%
Smoking Cessation	43	.03%
Parents Magazine	49	.03%
Healthy Family Initiative	60	.04%
Hypoallergenic bedding	104	.07%
Safe-link cell phone minutes	3,061	2.22%
Taking care of baby and me- *Gift card incentive	605	.43%
Respite Care	0	0%

- Over the counter drugs
- 2013-2014 VABs being modeled

Member Incentives

Value Added Benefits and Services

Total Members Received Value Added Benefits and Services:

- Convey Health OTC Rewards Benefit **32,409**
- Dental Benefit **36,255**
- Vision Benefit **13,291**

(There are no planned changes in Value Added Benefits & Services.)

Member Incentives

VALUE ADDED BENEFITS & SERVICES

Value Added Incentives for Wellness Visits

- No changes to the CentAccount Program a planned for 2013

CentAccount Member Rewards	# Eligible (Current)	# Receiving (July-Dec 2012)	% Receiving	Total $
Total Membership	167,707			
Well Child Check Up (Age 0 to 21 years)	132,055	20,296	15.4%	$204,300
Well Adult Check Up (Age 22 years and older)	31,652	897	2.8%	$8,970
Chlamydia Screening (women 16 to 24)	15,312	3,494	22.8%	$34,940
Cervical Cancer Screening (women 21 to 64)	24,583	3,024	12.3%	$30,240
Breast Cancer Screening (women 40 to 69)	8,916	1,265	14.2%	$12,650
Comprehensive Diabetes Management		24		$460
Prenatal Pregnancy Visit		2,168		$21,680
After Pregnancy Visit		13		$130
Total Members Receiving Rewards		31,181		$313,370

Member Incentives

Value Added Benefits and Services

UnitedHealthcare Community Plan

Eat4Health, a partnership between UnitedHealthcare and 4H, teaches school kids healthy habits through fun curriculum centered on diet and exercise.

- 6,124 children were reached through Eat4Health events in 2012

$20 Walgreen's wellness card, offered to members who complete a PCP office visit within 90 days of enrollment and well-child visits in child's 3rd, 4th, 5th or 6th year.

- All members are eligible
- 2,750 members received the wellness card July-Dec 2012

Join 4 Me Childhood Obesity Program (classes began January 2013)

- 2012 Engagement = 8,043 engaged
- 2012 Enrollment = 15 enrolled

Approximately 84% of our membership are children who are eligible for membership to the Boys and Girls Club

- 180 members have utilized this benefit

No planned changes in Value Added Benefits & Services at this time.

UnitedHealthcare

Walgreens

join for me

BOYS & GIRLS CLUB

Member Incentives

Community Health Solutions of Louisiana

Healthy Incentive Programs

Reward Category	Members Qualified for Reward	Members Eligible for Reward	Percent
Adult Wellness Screening	8,891	48,760	18%
Adult Wellness Visit	603	29,605	2%
Child Well Visit	42,493	168,330	25%
Diabetes Screening	232	2,120	11%
Postpartum Visit after Delivery	1,882	5,476	34%

What are the roles of the Health Plans?

- **Responsibilities include, but aren't limited to:**
  - Care management
  - Quality management and compliance
  - Prior authorization of services
  - Network management
  - Member Services and Provider Services
  - Fraud and abuse monitoring and compliance
  - Maintaining a significant local presence, with key staff members in state

What protections are built into the program?

- Network adequacy requirements (time, distance and enrollment ratios)
- Prompt pay standards for clean claims
- Medical loss ratio (85%)
- Outcomes and performance reporting
- Financial transparency and reporting requirements
- Transition of care requirements
- Standards for timely submission of encounter data
- Sanctions for not meeting performance outcomes

What are the monitoring tools that will be used?

Monitoring Mechanism	Member CAHPS Survey	Provider Survey	Grievance & Appeal Log Reports	External Quality Review Organization Reports	Health Plan Performance Measures (HEDIS, HIPRA, AHRQ)	Health Plan Validated Performance Improvement Projects	Health Plan Reporting (Clinical, Operations & Financial	Administrative Performance Measures
Access to Care Standards								
Availability of Services	X		X	X			X	X
Network Adequacy	X		X	X	X		X	X
Coordination and Continuity of Care	X	X	X	X			X	
Special Health Care Needs	X			X	X		X	
Coverage and Authorization of Services	X	X	X	X			X	X
Structure and Operational Standards								
Provider Selection and Credentialing		X		X			X	
Confidentiality	X		X	X			X	
Enrollment and Disenrollment				X			X	
Grievance Systems	X		X	X			X	
Sub-contractual Relationships & Delegation				X			X	
Quality Measurement and Performance Improvement Standards								
Practice Guidelines				X	X	X	X	
QAPI				X		X	X	
Health Information Systems				X	X	X		
Performance Improvement Projects				X	X	X	X	X
Performance Measures				X			X	

How is Bayou Health ensuring Quality?

- Identifying recipients with special health care needs;
- Use of evidence-based clinical guidelines;
- Evaluation by an independent External Quality Review Organization;
- Reporting on 37 performance measure (PM) results; and
- Perform a minimum of two State-approved performance improvement projects (PIPs).

Performance Outcome Measures

Louisiana Administrative Performance Measurement Set

Measure	Minimum Performance Standard
Percent of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact.	≥95%
Percent of standard service authorization requests processed in timeframes in the contract	≥95%
Percent of expedited service authorization requests processed in timeframes in the contract	≥100%
Percent of calls to Health Plan's Member Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds	≥90%
Average hold time for calls to Members Services	≤ 3.0 minutes
Percent of calls to Member Services that are abandoned (Callers who call then hang up before a representative answers.)	≤ 5%
Percent of calls to Health Plan's Provider Services answered by a live person or directed to an automated call pickup system with IVR options within 30 seconds	≥90%
Average hold time for calls to Provider Services	≤ 3.0 minutes
Percent of calls to Provider Services that are abandoned (Callers who call then hang up before a representative answers.)	≤ 5%
Percent of Member Appeals received by the Health Plan and resolved (approved or denial upheld) within the timeframe of the contract	≥95%
Percent of Provider Appeals received by the Health Plan and resolved (approved or denial upheld) within the timeframe of the contract	≥95%
Percent of clean claims paid for each provider type within 15 business days	≥90%
Percent of clean claims paid for each provider type within 30 calendar days	≥99%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%

Incentive Based Measures

Access and Availability of Care	Effectiveness of Care		Use of Services
$$ Adults' Access to Preventive/ Ambulatory Health Services ** HEDIS	$$ Comprehensive Diabetes Care HgbA1C **HEDIS	$$ Chlamydia Screening in Women **HEDIS/CHIPRA	$$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life **HEDIS/CHIPRA
			$$ Adolescent Well-Care Visits **HEDIS/CHIPRA

Performance Outcome Measures

Level 1 Measures

Access and Availability of Care	Effectiveness of Care		Prevention Quality Indicators	Use of Services
Children and Adolescents Access to PCP ** HEDIS/CHIPRA	Childhood Immunization Status **HEDIS/CHIPRA	Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents **HEDIS/CHIPRA	Adult Asthma Admission Rate **AHRQ	Well-Child Visits in the First 15 Months of Life **HEDIS/CHIPRA
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) **HEDIS/CHIPRA	Immunizations for Adolescents **HEDIS/CHIPRA	Use of Medication for people with Asthma **HEDIS/CHIPRA	CHF Admission Rate **AHRQ	Ambulatory Care (ER Utilization) **HEDIS
	Cholesterol Management for Patients with cardiovascular conditions **HEDIS	Comprehensive Diabetes Care **HEDIS	Uncontrolled Diabetes Admission Rate **AHRQ	
	Cervical CA Screening **HEDIS	Breast CA Screening **HEDIS/CHIPRA	Plan All-Cause Readmissions **HEDIS Adapted for Medicaid	
	EPSDT Screening Rate **CMS 416			

Level 2 Measures

Effectiveness of Care		Use of Services	Satisfaction and Outcomes
Follow-Up Care for Children Prescribed ADHD Medication **HEDIS/CHIPRA	Cesarean Rate for Low-Risk First Birth Women **CHIPRA	Emergency Utilization-Avg # of ED visits per member per reporting period **CHIPRA	CAHPS Health Plan Survey 4.0, Adult Version **HEDIS
Otitis Media Effusion **CHIPRA	Appropriate Testing for Children With Pharyngitis **HEDIS/CHIPRA	Annual # of asthma patients (1yr old) with 1 asthma related ER visit **CHIPRA	CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions **HEDIS/CHIPRA
Controlling High Blood Pressure **HEDIS	% of Pregnant Women who are screened for tobacco usage and secondhand smoke exposure and are offered an appropriate and individualized intervention ** State	Frequency of Ongoing Prenatal care **HEDIS/CHIPRA	Provider Satisfaction **State
Pediatric Central-Line Associated Bloodstream Infections **CHIPRA	Total number of eligible women who receive 17-OH progesterone during pregnancy, and % of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients ** State		
Percent of live births weighing less than 2,500 grams **CHIPRA			

What kind of accountability is there?

- Prepaid Plans: Up to 2.5% of monthly PMPM can be withheld if quality benchmarks are not reached
- For Prepaid Plans, once quality measures are available, preference is given in auto assignment to best performers
- Hefty financial sanctions for failure to perform satisfactorily, including things like:
  - Failure to maintain an adequate network
  - Failure to submit complete and accurate encounter data
  - Failure to promptly pay claims
  - Failure to provide medically necessary items and services
  - Unreasonable telephone hold time

Member Success Stories

Through case and disease management programs not provided in legacy Medicaid, Bayou Health Plans have had a direct and meaningful impact on the lives of their members, even in the few short months since implementation.

Member Stories - Amerigroup

70% Reduction in Bayou Health Member's Quarterly ER Visits

The Amerigroup case manager:

- coordinated care and reconciled medication with the member's primary care provider, physician at Coumadin Clinic, vascular physician and home health provider;
- assisted with making appointment for behavioral health;
- arranged transportation;
- and educated member on appropriate ER use and alternative settings.

Result: Quarterly ER visits were reduced by 70% (from 30 to nine) for a member with multiple morbidities including fibromyalgia, lupus, seizures, asthma, osteomyelitis, depression, anxiety and allergies.

Ramp built, accessibility gained

The Amerigroup case manager:

- identified an accessibility need for their member and a potential solution;
- linked the member with an organization that specifically donates wheelchair ramps;
- worked to raise money associated for the cost of ramp supplies through donating partners;
- communicated directly with the wheelchair donating agency to place member on a waiting list; and
- used contact time with member to educate on keeping appointments, PCP usage versus the ER.

Member Story - Amerigroup

Reduction of ER usage, Pain levels managed
The Amerigroup case manager:

- identified a “frequent flyer” to the ER for daily IV pain medication for treatment of Sickle Cell Disease;
- scheduled several appointments and arranged transportation to Sickle Cell Clinic where member failed to show;
- educated member on proper use of ER, importance of keeping appointments; and
- reassessed member’s needs and coordinated with PCP and member toward a more workable solution for all – providing member with pain pump for pain management.

Result: Member on track toward better quality of life, through the management of pain with approval of an authorized pain pump and scheduled appointment with surgeon for port placement.

Member Story – Community Health Solutions

Child with Cerebral Palsy Regains Ability to Communicate with Family

The CHS case manager:

- identified child through targeting high risk patients for case management;
- determined software had been previously given to family that would greatly assist child with communications, but family did not have computer to use the software; and
- located a donated computer to be used by the child;

Result: Child's ability to communicate with family has been greatly improved.

Case Management Prevented Impending Hospital Readmission

The CHS case manager:

- identified member with COPD as being unable to walk since recent hospital discharge and could not navigate stairs into or out of her home:
- determined that no one ordered the needed DME at time of discharge; and
- ordered DME, home health and needed therapies.

Result: Member is now receiving necessary physical therapy which has allowed her to gain mobility, leave her home and reconnect with PCP for preventative care.

Member Story – LaCare

Improved health, self-management of diabetes with case management support

The LaCare case manager:

- identified member with poor disease management and compliance with medical appointments and medication management for multiple morbidities;
- developed care plan encouraging self-management, medication, health education; and
- referred to community resource for assistance with clothing and food needs.

Result: Decrease in HGB levels and successful weight loss, leading to decreased need for frequent lab monitoring.

Post-op physical, behavioral health coordinated

The LaCare case manager:

- identified a post-transplant member with surgery related stress in need of behavioral health services;
- recognized that, prior to discharge, transition of care needs had not been supplied;
- worked with transportation service and Magellan to arrange therapy; and
- collaborated with member and family to ensure any needed physical health services, including home health, were provided.

Result: Following third double lung transplant, member has much needed therapy provided as well as comprehensive care for physical health needs.

Member Story – Louisiana Healthcare Connections

Smart Start case management delivers successful prenatal care

The LHC case manager:

- worked with enrollee who joined plan 24-weeks into pregnancy with multiple health concerns requiring bed rest;
- educated member on compliance with medications and doctor's guidance; and
- assisted in pediatrician selection and helped member locate resources for car seat and utility assistance.

Result: Member delivered a healthy baby at 39 weeks.

Homeless member benefits from behavioral, social support

The LHC case manager:

- received a call from a homeless member with behavioral and physical health needs who was not seeing a PCP regularly;
- worked to link member to a PCP and mental health treatment, as well as transportation for both; and
- connected member with agencies for housing and food resources.

Result: Member has secured housing with support staff to assist him as needed, has regular visits with his PCP, takes his medicines as prescribed and has the support of case management and care coordination for any social needs that may arise.

Member Story – UnitedHealthcare

Self-management tools aid member with multiple morbidities to graduate case management

The UHC case manager:

- identified a member with multiple behavioral and physical health care needs who was medically non-compliant and using the ER for primary care.
- scheduled appointments with a primary care provider, ophthalmologist and coordinated mental health services; and
- secured blood pressure and glucose monitors for home use to promote in-home disease management.

Result: Member regularly visits physicians in the proper setting and understands the medicines he must take and the importance of monitoring his own health. Member has improved to the point of no longer needing case management.

Bayou Health Reporting

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3rd & 4th Quarter Reports

(July through December 2012)

http://new.dhh.louisiana.gov/index.cfm/page/1582

April 9, 2013

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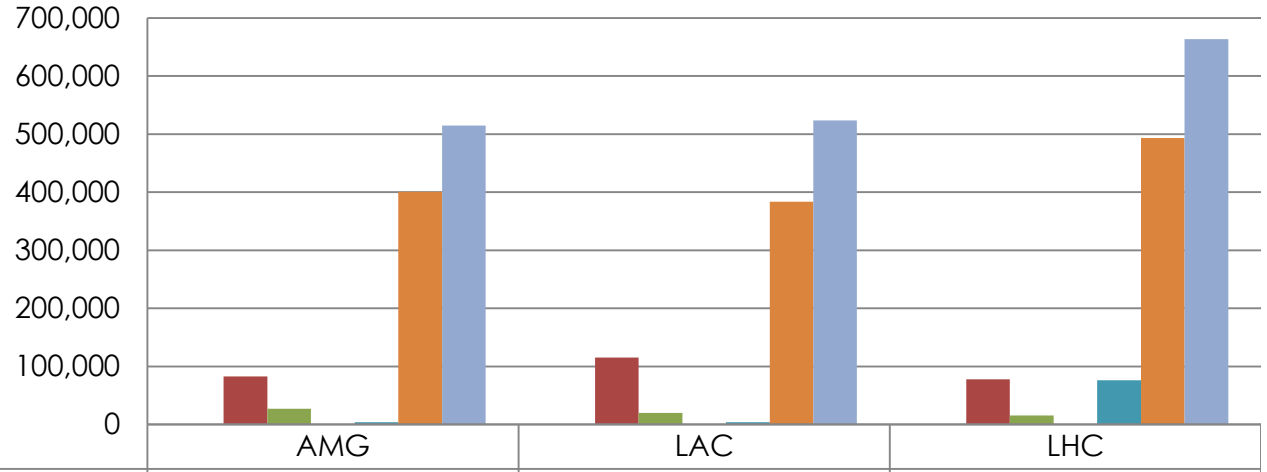
Denied Claims
By Prepaid Health Plan By Reason
3rd and 4th Quarter (July through December 2012)



	AMG	LAC	LHC
Lack of documentation to support Medical Necessity	264	2	343
Prior Authorization was not on file	82,831	115,641	77,953
Member has other insurance that must be billed first	27,170	19,950	15,444
Claim was submitted after the filing deadline	0	0	174
Service was not covered by Medicaid	4,107	4,000	76,041
All Other (for example: terminations, duplicate claims and EOB charges do not match claim, etc.)	400,500	383,842	493,568
Totals	514,872	523,435	663,523

Source: Bayou Health Report 173 self reported by Health Plans

Examples of All Other include terminations, duplicate claims and EOB charges do not match claim.

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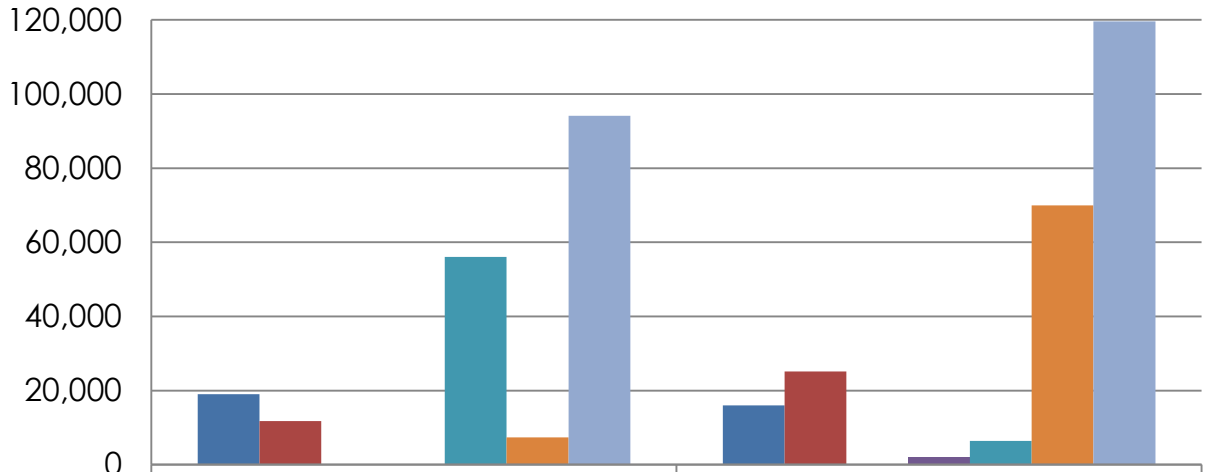
Pre-Processing Denials
By Shared Savings Health Plan By Reason
3rd and 4th Quarter (July through December 2012)



	CHS	UHC
Lack of documentation to support Medical Necessity	19,044	16,025
Prior Authorization was not on file	11,755	25,171
Member has other insurance that must be billed first	0	0
Claim was submitted after the filing deadline	0	2,044
Service was not covered by Medicaid	56,019	6,395
All Other	7,347	69,964
Totals	94165	119599

Source: Bayou Health Report 173 self reported by Health Plans

Shared Savings Health Plans (CHS and UHC) – include only denials directly by Health Plan during pre-processing. Other denials may result from final adjudication by the Fiscal Intermediary (Molina). Examples of All Other include terminations, duplicate claims and EOB charges do not match claim.

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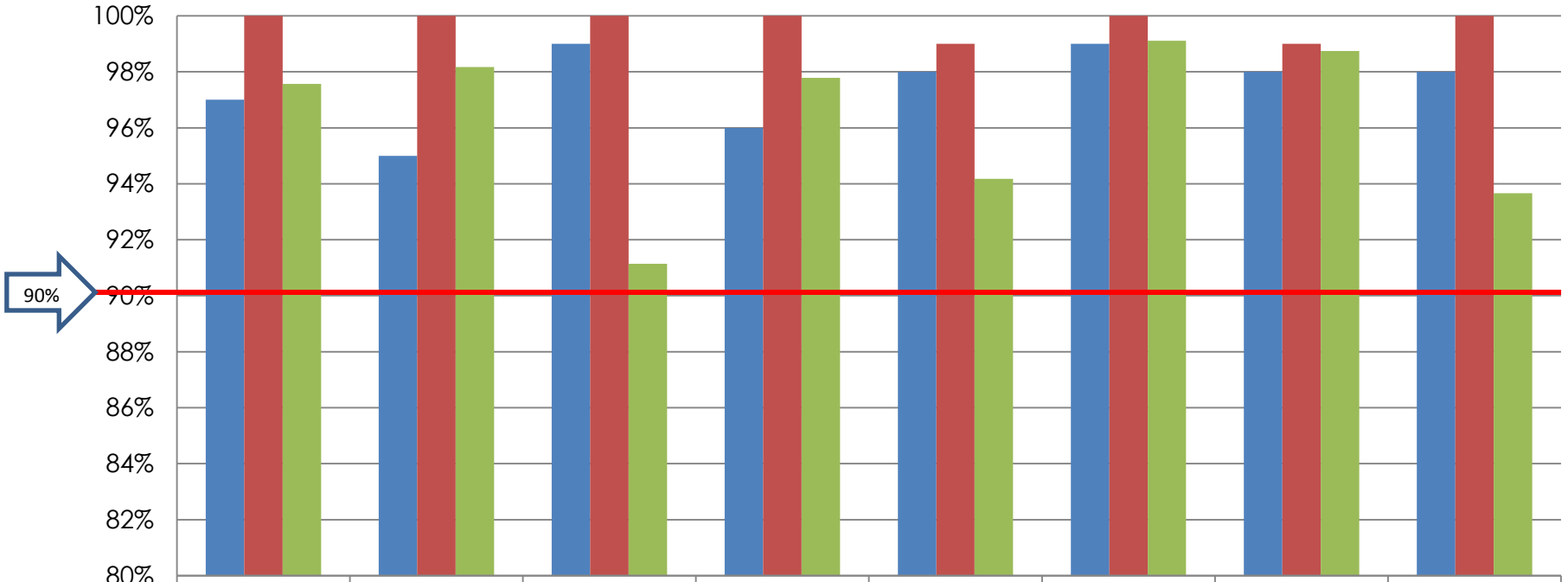
Percent of Clean Claims Paid in less than 15 business days

By Prepaid Health Plan

3rd Quarter (July, August and September 2012)



	DME	EMT (Transport)	Home Health	Inpatient Hospital	NEMT (Transport)	Outpatient Hospital	Professional	Rehab
AMG	97%	95%	99%	96%	98%	99%	98%	98%
LAC	100%	100%	100%	100%	99%	100%	99%	100%
LHC	98%	98%	91%	98%	94%	99%	99%	94%

Source: Bayou Health Report 221 Prompt Payment self reported by Health Plans

The minimum performance standard for clean claims to be paid in less than 15 days is ≥90%.

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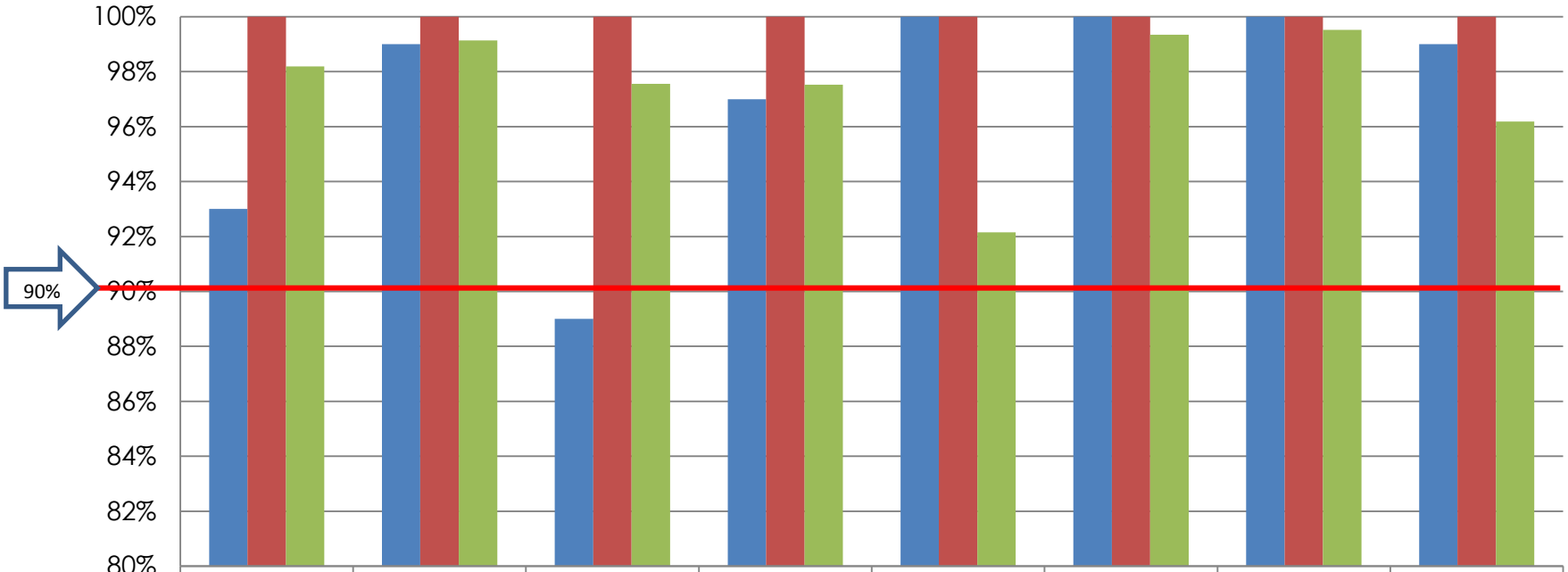
Percent of Clean Claims Paid in less than 15 business days

By Prepaid Health Plan

4th Quarter (October, November and December 2012)



	DME	EMT (Transport)	Home Health	Inpatient Hospital	NEMT (Transport)	Outpatient Hospital	Professional	Rehab
AMG	93%	99%	89%	97%	100%	100%	100%	99%
LAC	100%	100%	100%	100%	100%	100%	100%	100%
LHC	98%	99%	98%	98%	92%	99%	100%	96%

Source: Bayou Health Report 221 Prompt Payment self reported by Health Plans

The minimum performance standard for clean claims to be paid in less than 15 days is ≥90%.

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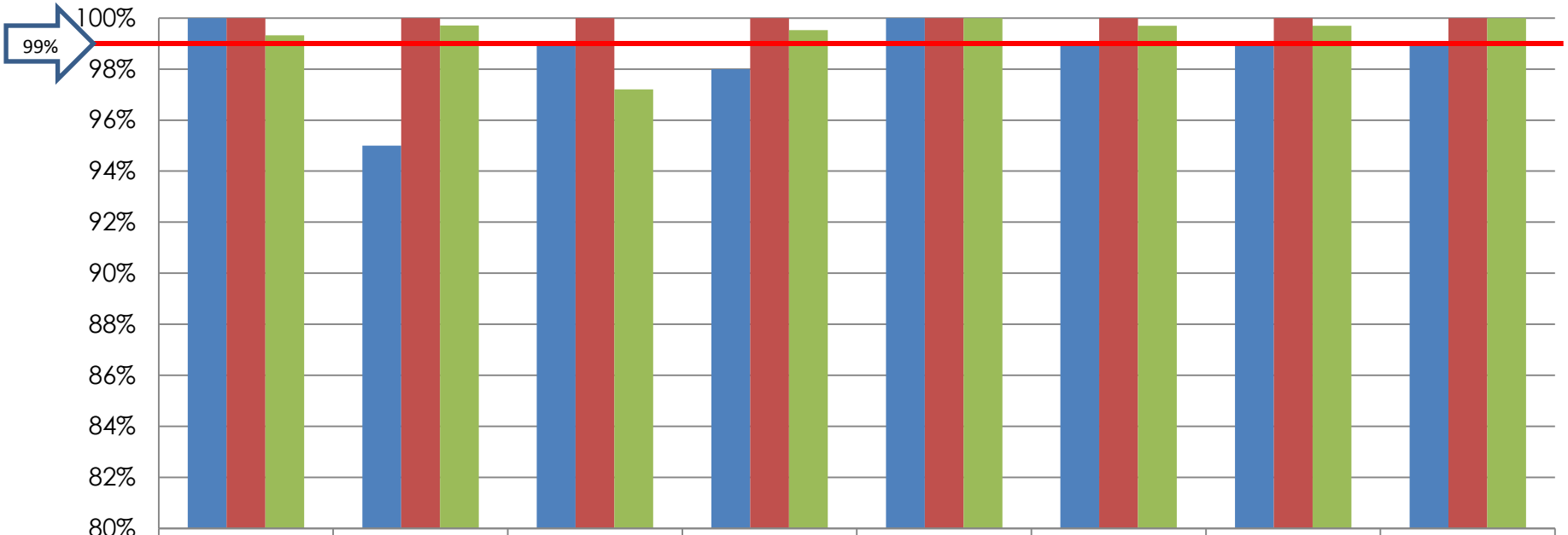
Percent of Clean Claims Paid in 30 calendar days or less

By Prepaid Health Plan

3rd Quarter (July, August and September 2012)



	DME	EMT (Transport)	Home Health	Inpatient Hospital	NEMT (Transport)	Outpatient Hospital	Professional	Rehab
AMG	100%	95%	99%	98%	100%	99%	99%	99%
LAC	100%	100%	100%	100%	100%	100%	100%	100%
LHC	99%	100%	97%	100%	100%	100%	100%	100%

Source: Bayou Health Report 221 Prompt Payment self reported by Health Plans

The count of clean claims processed between 01 and 30 calendar days from date received to payment (% - calculated percentage by dividing number of claims processed in reporting period by total claims processed). The minimum performance standard for clean claims to be paid in 30 days or less is ≥99%.

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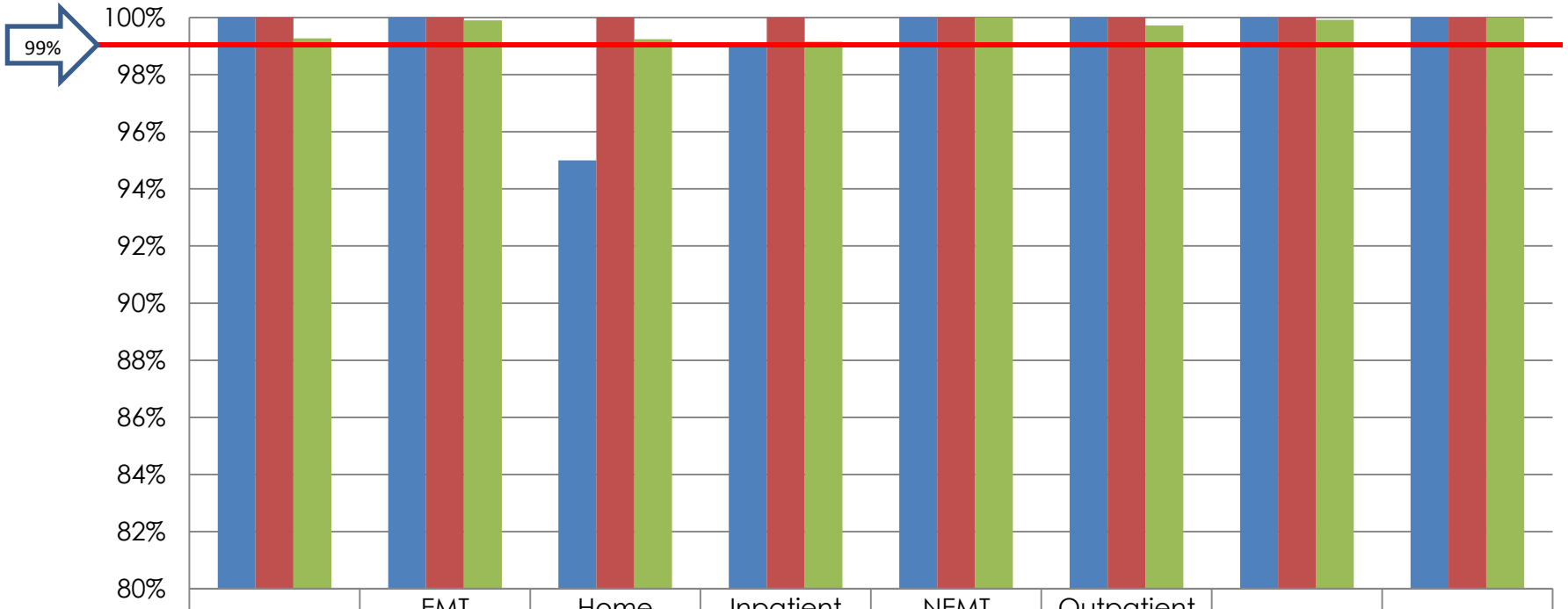
Percent of Clean Claims Paid in 30 calendar days or less

By Prepaid Health Plan

4th Quarter (October, November and December 2012)



	DME	EMT (Transport)	Home Health	Inpatient Hospital	NEMT (Transport)	Outpatient Hospital	Professional	Rehab
AMG	100%	100%	95%	99%	100%	100%	100%	100%
LAC	100%	100%	100%	100%	100%	100%	100%	100%
LHC	99%	100%	99%	99%	100%	100%	100%	100%

Source: Bayou Health Report 221 Prompt Payment self reported by Health Plans

The count of clean claims processed between 01 and 30 calendar days from date received to payment (% - calculated percentage by dividing number of claims processed in reporting period by total claims processed). The minimum performance standard for clean claims to be paid in 30 days or less is ≥99%.

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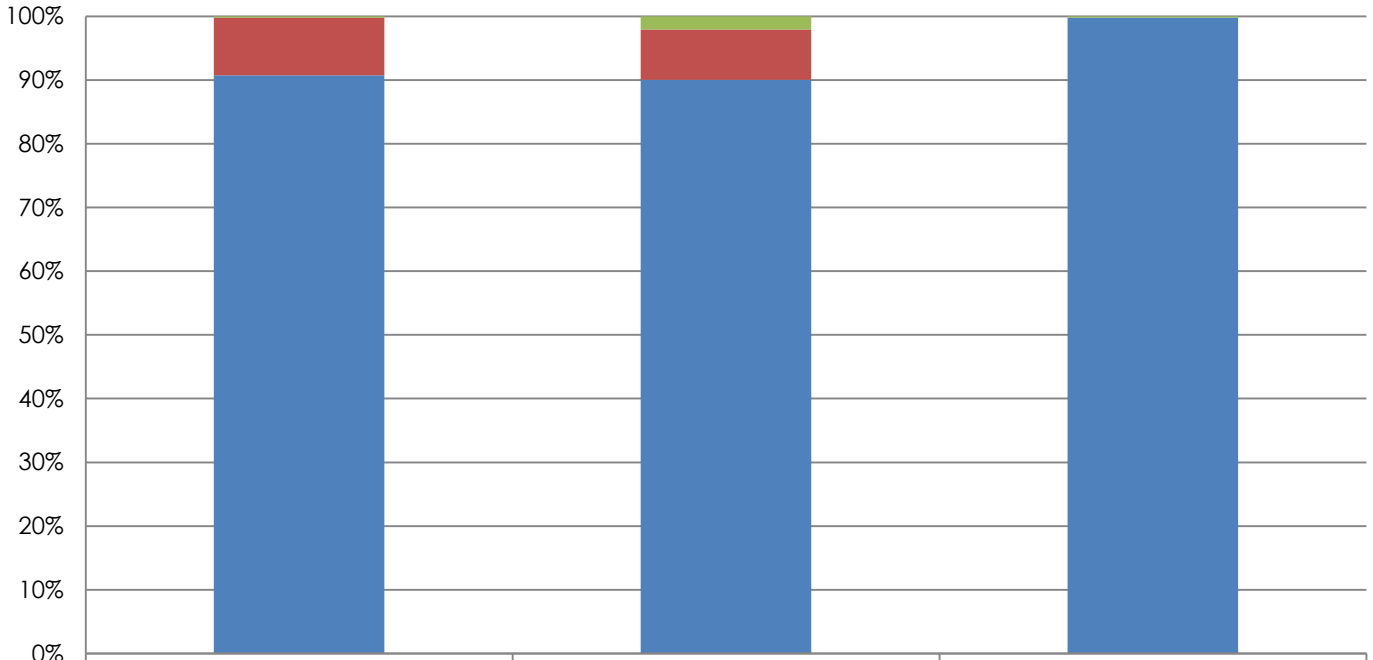
Prior Authorization Summary for Standard Authorizations
By Prepaid Health Plans
4th Quarter (October, November and December 2012)



	AMG	LAC	LHC
15-28 business days	0.19%	2.09%	0.22%
14 business days	9.08%	7.88%	0.00%
2 business days	90.73%	90.03%	99.78%

Source: Bayou Health Report 188 Prior Authorization & Pre-Certification Summary - self reported by Health Plans

Miminum performance standard from time all required documentation is received by the plan: 80% within 2 days, 100% within 14 days, unless an extension is requested and approved by DHH for a maximum of 28 days for all standard PA decisions. (Does not include DME and Pharmacy - which are reported separately.)

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Prior Authorization Summary for Standard Authorizations
By Shared Savings Health Plans
4th Quarter (October, November and December 2012)

	CHS	UHC
15-28 business days	0.00%	0.00%
14 business days	0.02%	0.28%
2 business days	99.98%	99.72%

Source: Bayou Health Report 188 Prior Authorization & Pre-Certification Summary - self reported by Health Plans
Miminum performance standard from time all required documentation is received by the plan: 80% within 2 days, 100% within 14 days, unless an extension is requested and approved by DHH for a maximum of 28 days for all standard PA decisions.

QAPI PCP Profile Report

Health Plan ID: 2162438
Health Plan Name: UnitedHealthcare Community Plan of Louisiana
Health Plan Contact: Michael Dickey

Contact Email: michael_dickey@uhc.com
Report Period Start Date: 20120101
Report Period End Date: 20121231

BAYOU HEALTH Reporting

Document ID: S072
Document Name: QAPI PCP Profile Reports
Reporting Frequency: Quarterly (due 4/30, 7/30, 10/30, 01/30); Annually (included with 01/30 report)
Report Due Date: 30th of the month following end of reporting period
File Type: Excel
Subject Matter: Quality (Q)

MONTHLY SUMMARY:

Plan ID	Month (MMM-YYYY)	# Members	# Specialist Referrals	# Low-level ER Visits	# Mid-level ER Visits	# High-level ER Visits	# Hospital Admissions	# Lab Services	# Radiology Services	# Medications	# Recipients with > 12 Office Visits
2162438	Jan-2012	0	0	0	0	0	0	0	0	0	0
2162438	Feb-2012	59728	6550	210	1430	1060	476	6281	3389	42888	0
2162438	Mar-2012	65626	2272	87	511	446	244	4386	1741	8007	0
2162438	Apr-2012	150694	10603	375	3205	2519	775	13738	7523	72980	2
2162438	May-2012	159928	14233	604	4401	3345	1078	17381	10282	91915	13
2162438	Jun-2012	229890	19077	763	5631	4043	1499	21901	13073	170517	73
2162438	Jul-2012	236869	25017	862	6342	4781	1794	25963	15002	174233	189
2162438	Aug-2012	238321	26523	839	6585	5168	1682	26886	15083	190100	407
2162438	Sep-2012	238656	27126	987	7355	5400	1612	27066	16146	197746	700
2162438	Oct-2012	239461	31430	946	7521	5332	1636	31051	18203	221527	1265
2162438	Nov-2012	239332	27501	786	7092	5151	1467	26864	15766	208804	1743
2162438	Dec-2012	237296	18382	357	4045	2841	901	20144	9746	193801	1766
2162438	YTD 2012 (unduplicated)	268568	208714	6816	54118	40086	13164	221661	125954	1572518	6158

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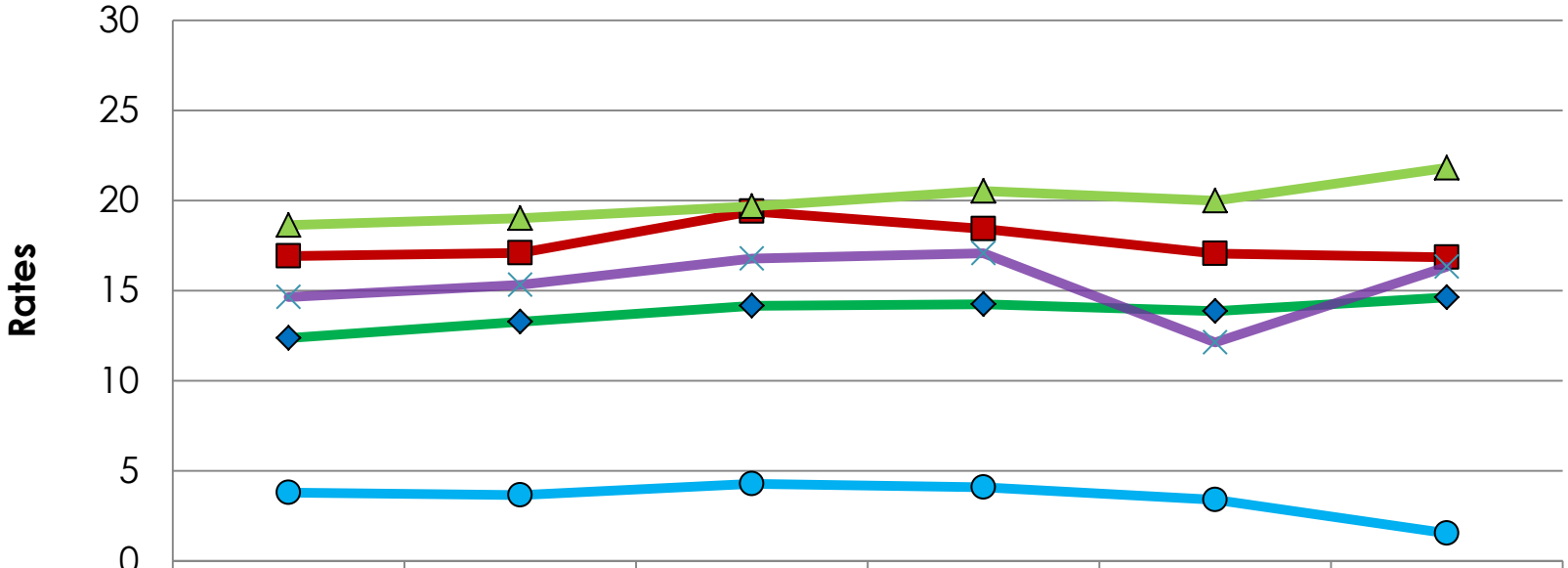
Low Level Emergency Rate by Health Plan
(per 1,000 members)
3rd and 4th Quarter (July – December 2012)



	Jul	Aug	Sep	Oct	Nov	Dec
AMG	12.4	13.3	14.2	14.3	13.9	14.6
LAC	16.9	17.1	19.4	18.4	17.1	16.8
LHC	18.6	19.0	19.7	20.5	20.0	21.8
CHS	14.6	15.3	16.8	17.1	12.1	16.3
UHC	3.8	3.7	4.3	4.1	3.4	1.5

Source: Bayou Health Report 072 PCP Profile self reported by Health Plans

The Low Level Emergency Rates are determined by using CPT codes 99281 and 99282. Rates are calculated based on the number of visits per 1,000 members.

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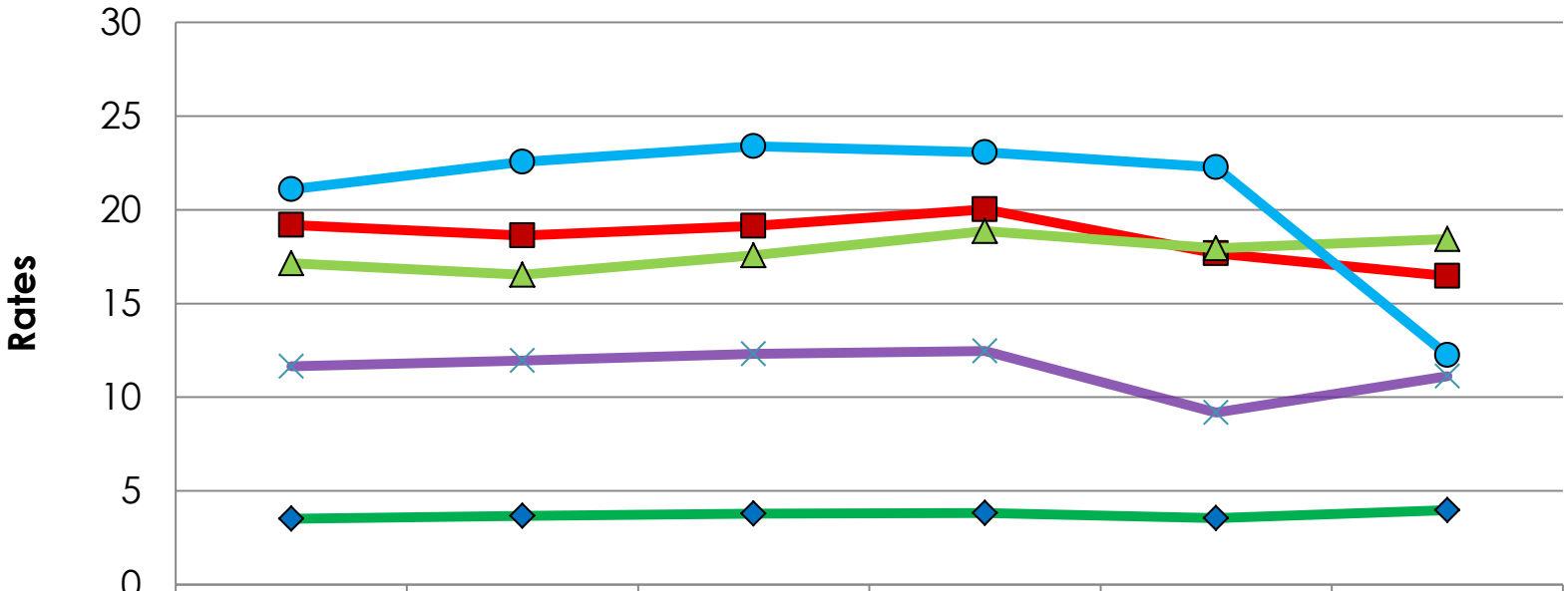
High Level Emergency Rate by Health Plan
(per 1,000 members)
3rd and 4th Quarter (July – December 2012)



	Jul	Aug	Sep	Oct	Nov	Dec
AMG	3.5	3.7	3.8	3.8	3.6	4.0
LAC	19.2	18.6	19.1	20.0	17.7	16.5
LHC	17.2	16.5	17.6	18.9	18.0	18.4
CHS	11.6	11.9	12.3	12.5	9.2	11.1
UHC	21.1	22.6	23.4	23.1	22.3	12.2

Source: Bayou Health Report 072 PCP Profile self reported by Health Plans

The High Level Emergency Rates are determined by using CPT codes 99284 and 99285. Rates are calculated based on the number of visits per 1,000 members.

Provider Complaint & Appeal Summary Report

BAYOU HEALTH Reporting

Health Plan ID: 2162934
Health Plan Name: LaCare
Health Plan Contact: Melissa Bezet
Contact Email: melissa.bezet@lacarelouisiana.com
Report Period Start Date: 20121201
Report Period End Date: 20121231

Document ID: PI182
Document Name: **PROVIDER COMPLAINT & APPEAL SUMMARY REPORT**
Reporting Frequency: Monthly
Report Due Date: 15th of the month following end of reporting period
File Type: Excel
Subject Matter: Informatics (I)

Summary of Appeal Decisions	By Health Plan	By Arbitration
Total # Decisions	2	0
% Upheld	50	0
% Overturned	50	0
% Withdrawn	0	0

Reporting Period	COMPLAINT STATUS	Total # of Provider Complaints	# of COMPLAINTS by ISSUE CATEGORY							# Complaints Pending or Closed 31 to 90 Days Post File Date[1]	# Complaints Pending or Closed >90 Days Post File Date[1]	Total Provider Appeals	By Appeal Type		# Appeals Pending or Closed 31 to 90 Days Post File Date[2]	# Appeals Pending or Closed >90 Days Post File Date[2]
			Claims / Payments	Covered Services	PAs/Referrals	PCP Auto-Assign/ Linkages	Provider Registry/ Directory	Lack of Information /Response	Other				Pre-Service Denial	Payment Denial		
Dec-2012	**Received this Month**	821	759	1	6	0	2	1	52			2	2			
	Total Closed this Month	931	865	2	5	0	3	1	55	43		2	2			
	Withdrawn by Provider															
	Per Internal Plan Action/Decision	931	865	2	5	0	3	1	55	43		2	2			
	Per Independent Arbitration															
	Per DHH Review															
	Other (Review determined not a complaint)															
	Total Pending (cumulative as of month end)	82	78	0	1	0	2	0	1	11						
	Information needed from Provider															
	Internal Plan Review	82	78	0	1	0	2	0	1	11						
	Independent Arbitration															
	DHH Review															
	Other (Review determined not a complaint)															
2012 Year to Date (YTD)	**Total Complaints Received YTD**	5632	4947	18	23	1	51	24	568			15	15			
	Total Closed YTD	5550	4869	18	22	1	49	24	567	209	10	15	15			
	Withdrawn by Provider															
	Per Internal Plan Decision/Correction	5541	4861	18	22	1	49	24	566	205		15	15			
	Per Independent Arbitration															
	Per DHH Decision															
	Other (Review determined not a complaint)	9	8	0	0	0	0	0	1	4						

[1] **You must submit Attachment 1 - Complaint Summary Listing detailing all pending or closed (A1) complaints not resolved within 30 to 90 days**

[2] **You must submit Attachment 2 - Appeal Summary Listing detailing all pending or closed (A1) appeals not resolved within 30 to 90 days.**

Lacare

BAYOU HEALTH Grievances and Appeals Report

II. Review Activities

	Grievances	Appeals	State Fair Hearings
Number of grievances/appeals reviewed:	134	40	10
Number of grievances/appeals resolved:	154	25	1
Number of State Fair Hearing level appeals withdrawn:	NA	NA	9
Number of grievances/appeals considered invalid:	1	18	0
Average length of time to complete each grievance/appeal/State Fair Hearing:	23	11	0
Number of overturned decisions at State Fair Hearing Level:	NA	NA	0
Number of health plan appeals reversed in the member's favor:	NA	18	0
Percentage of appeals overturned at the State Fair Hearing level:	NA	NA	0

In health plan level appeals where the decision was reversed in the member's favor, what were the most common reasons?
Services requested do not meet LaCare's criteria for medical necessity
Documented trial and failure
History warrants approval
Lack of clinical documentation

In State Fair Hearing cases where the decision was overturned in the member's favor, what were the most common reasons?

List the top 5 reasons that were most commonly the subject of grievances/appeals:
Lack of Concern/Uncaring Attitude
Difficulty Obtaining Appointment
Office Staff is Rude/Inconsiderate
Customer Service Quality
Clinical/Quality Care

Additional Information Required for Annual Report Submission

	Grievances	Appeals	State Fair Hearings
Number still pending at the end of Contract Year 2012:	32	2	0
Percentage of appeals reversed in Contract Year 2012:	NA	35	0

LaCare
Reason Summary Chart

Reason Number Code	Reason	Number of Grievances	Number of Appeals	Number of State Fair Hearings
1	Quality of Care	33	0	0
2	Accessibility of office	24	0	0
3	Attitude/Service of staff	50	0	0
4	Quality of office, building	0	0	0
5	Timeliness	0	4	0
6	Billing and Financial issues	3	0	0
7	Clinical Criteria Not Met - Durable Medical Equipment	19	7	1
8	Clinical Criteria Not Met - Inpatient Admissions	0	1	0
9	Clinical Criteria Not Met - Medical Procedure	0	2	0

5	Timeliness	0	4	0
6	Billing and Financial issues	3	0	0
7	Clinical Criteria Not Met - Durable Medical Equipment	19	7	1
8	Clinical Criteria Not Met - Inpatient Admissions	0	1	0
9	Clinical Criteria Not Met - Medical Procedure	0	2	0
10	Prior or Post Authorization	4	20	1
11	Lack of Information from Provider	0	2	4
12	Level of Care Dispute	0	0	0
13	Not a State Plan Services	0	2	3
14	Other (Must provide description in narrative column of Summary Reports)	1	0	1
	TOTALS	134	38	10

DO NOT ADD OR CHANGE REASON CODES

Contact Information

Member Enrollment: Call 1-855-BAYOU4U

Plan	Provider Relations	Member Services	Web Site
Amerigroup RealSolutions in healthcare	1-800-454-3730	1-800-600-4441	myamerigroup.com/la
LaCare A Program of AmeriHealth Mercy of Louisiana, Inc.	1-888-922-0007	1-888-756-0004	lacarelouisiana.com
Louisiana Healthcare Connections	1-866-595-8133	1-866-595-8133	LouisianaHealthConnect.com
CHS Community Health Solutions of Louisiana	1-855-247-5248	1-855-247-5248	louisiana.chsamerica.com
UnitedHealthcare	1-866-675-1607	1-866-675-1607	UHCCommunityPlan.com

QUESTIONS?

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www.Makingmedicaidbetter.com
http://new.dhh.louisiana.gov/index.cfm/page/1582